PAIN MANAGEMENT AGREEMENT (sample copy – August 2011)

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your providers to comply with the law regarding controlled pharmaceuticals.

I (PATIENT) understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my provider will stop prescribing these pain control medications, and may terminate my care. In this case, my provider may choose to taper me off of my medication, or discontinue the medication and prescribe medication to treat the withdrawal symptoms. This choice will be made my provider.

I will communicate fully with my provider about the character and intensity of my pain, the effect that my pain has on my daily life, and how well the medication is helping to relieve my pain.

I will not use illegal controlled substances including marijuana, cocaine, etc.

I will not share, sell or trade my medications to anyone. Altering a prescription in any manner, selling medications, or misrepresenting myself to a pharmacy is a serious offense. It is a felony and will be reported to the police.

I will not attempt to obtain controlled medications including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider or physician.

I will safeguard my medications from loss or theft. Lost or stolen medications will NOT be replaced. To reduce instances of medication loss/theft, carry only the amount of medications that you will be using when away from home. Given the recent publicity regarding opiate abuse, it is wise for you to keep confidential the type of medication that you are taking.

I agree that refills of my prescriptions for pain medicines will be made at the time of an office visit or during regular office hours. If you fail to come to a scheduled appointment without notifying us PRIOR to that appointment you will not be given a refill until you are seen.

NO REFILLS WILL BE A VAILABLE UNDER ANY CIRCUMSTANCES DURING THE EVENINGS OR ON THE WEEKENDS.

I agree to use _____ Pharmacy, located at _____.

Telephone number _____ for filing prescriptions for all of my pain medicines.

I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State Board of Pharmacy. in the investigation of any possible misuse, sale. or other diversion of my pain medications. I authorize my provider to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right or privacy or confidentiality with respect to these authorizations.

I agree to submit to a blood or urine test **at my cost** if requested by my provider to determine my compliance with my program of pain control medications. Refusal to submit to this testing will result in my ***IMMEDIATE TERMINATION OF CARE*** by the provider.

I agree that I will use my medications at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medications for a period of time. Continued misuse of medication will result in termination of my care from this provider.

If you are hospitalized while under the care of the provider and have questions for our providers, your hospital nurse taking care of you will call the clinic. You are not to call the clinic when you are hospitalized.

I agree to these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me and a signed copy of this Agreement will be placed in my medical record.

This Agreement is entered into on this _____ day of _____ 20XX.

Patient Signature:

Provider Signature:

Witnessed By: